those in Essex highlighted another characteristic which makes this community special—the volunteer spirit of its residents. Until recently, virtually every local official served without pay and many continue to do so today. Fires are fought by volunteers, school playgrounds are built by parents, and elections are monitored by civic-minded citizens who never receive a penny for their dedication to their community. Mr. Richard Gamble summed up the contribution of Essex's residents by saying ''we're unusually blessed by people who are not only capable, but willing to spend the time.''

Mr. Speaker, I am proud to joint residents from Essex in celebrating this much deserved honor. Parochially, I believe every small town across the Second Congressional District could qualify for the No. 1 spot. However, today we celebrate the achievements of this community and welcome people from across the country to come join us in America's No. 1 Small Town—Essex.

TRIBUTE TO THE NORTHWESTERN WILDCATS

HON. SIDNEY R. YATES

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 5, 1995

Mr. YATES. Mr. Speaker, our long, long wait is over. The Northwestern Wildcats are going to the Rose Bowl.

The last time Northwestern went to the Rose Bowl was in 1949, my first year in Congress. Back then we all thought there was a dynasty in the making; we felt sure the Wildcats would play in the Rose Bowl for years to come. I never dreamed that I'd have to wait 46 years to see this moment again. But I am a patient man and this victory is well worth the wait. And knowing both the 1949 team and our current champions, I feel safe in saying that the Wildcats, like Congressmen, improve with age.

Thanks to a dedicated and talented Wildcat team, the leadership and patience of its coach, Gary Barnett, and the continuing insistence of Northwestern President Henry S. Bienen and Chancellor Arnold R. Weber that a university could simultaneously have academic and athletic excellence, the Big Ten Champion Wildcats will be playing in Pasadena on New Year's Day. These are accomplishments which should be celebrated in an era of athlete factories and degree mill universities. The Wildcats have the second highest team average SAT score in all of NCAA Division I. Newsweek notes that every one of Gary Barnett's players who didn't transfer to another school has continued on to graduation. The Wildcats, with grace and spirit, demonstrated that winning and learning are not inconsistent.

It is out of this incredible pride that I feel for Northwestern that I am today introducing a resolution which recognizes the amazing accomplishments of the Wildcats and congratulates them on winning the 1995 Big Ten Championship and on receiving the coveted invitation to compete in the 1996 Rose Bowl.

As an old alum from the University of Chicago, I long considered the Wildcats to be bitter rivals. But today, we are all Northwestern fans.

And regardless of the final outcome of the game, the Wildcats and all of Northwestern are winners.

REAL TALK ABOUT MEDICARE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 5, 1995

Mr. STARK. Mr. Speaker, I commend to my colleagues an opinion piece in today's Washington Post. Professors Jerry Mashaw and Theodore Marmor provide a straight to the point analysis of what maintaining the best health insurance program in the world, Medicare, requires.

REAL TALK ABOUT MEDICARE

Although Medicare reform has been at the very center of the budget negotiations between Congress and the administration, much of the political discussion on this issue has been about as thoughtful as a food fight.

Republicans have made the claim that Medicare faces bankruptcy and offered their ''Medicare Preservation Act,'' cutting $270 billion in projected spending on the program in order to ''preserve, protect and strengthen'' the program. Democrats respond that this would mean Medicare's destruction and that big cuts are unnecessary—except to facilitate tax cuts for the rich while keeping the Republican promise to eliminate the deficit.

Behind this unilluminating, alarmist debate there are some hard facts that need to be considered:

Medicare does need fiscal adjustment. A 10 percent annual growth rate in program costs is simply not sustainable in the long run. Changes in longevity, medical technology, cultural conceptions of adequate medical care, national fiscal capacity and a host of other factors demand that any long-term program of medical insurance accept periodic adjustments. Rigid defense of the status quo is silly. But so is the demand for ''preservation'' by complete overhaul. Reformers should attend to the many small adjustments that really will preserve a highly valued program. They should not search for some untried one big thing that will ''fix'' the system for all time.

Talk of the projected ''bankruptcy'' of the ''trust fund'' is an unhelpful way to think about the urgency of Medicare's financial problems. The trust fund is an accounting convention signaling that Medicare's hospital insurance (Part A) is financed by earmarked taxes. If time is needed to make sensible, gradual adjustments in Medicare, the ''fund'' for Part A can be increased by extremely modest new taxes or by temporary transfers from the surpluses in the Social Security retirement accounts. In any event, no one is going to wake up some Saturday morning to find that his hospital coverage has suddenly ceased because Medicare is ''broke.''

Costs are not the only problem. For example, major elements in the treatment of chronic disease are not covered by Medicare, nor are pharmaceutical therapies and long-term care. These gaps not only ensure that the program fails to meet important needs of the elderly and the disabled, they also promote costly gaming of the system. To get Medicare payments for nursing home care, patients must be cycled through hospital stays, whether needed or not. Personal assistance must be provided by highly paid nurses, even if the ''medical'' content of the care is minimal.

Reform should concentrate on helping Medicare meet the genuine needs of beneficiaries and avoid artificial boundaries that cannot, in any case, be policed effectively. Broadened coverage need not necessarily be the enemy of cost control and in some instances may be its ally.

Lest this proposal for expanded coverage suggest we have lost touch with fiscal reality, we must emphasize that the costs of care may be reduced in many ways. Less expensive forms of care can substitute for more heroic interventions. Unnecessary and marginally necessary care can be lessened. The amounts paid for particular interventions can be restrained.

But reformers should remember that Medicare administrators have been quite successful at constraining costs when given the tools and political support to do so. They can be even more effective in the current context, in which private insurers are doing similar things. Providers now have nowhere to hide from system-wide demands for cost control.

Taxes can be raised. So can premiums. Anyone who thinks that an earmarked tax for a popular program can't be increased marginally in the current political climate simply has not been paying attention to what we have been doing over the past decade—or to what opinion polls say Americans will support. On the other hand, there is no reason that a program originally designed to prevent financial catastrophe for the elderly and disabled should use general revenues to subsidize 80 percent of all their expenditures for physician services (Part B). Some of these costs can and should be distributed differently. In other words, reform should (and almost surely will) require some adjustments in current payment arrangements: who pays, how much and through what types of levies, charges or deductibles.

Finally, those who are old or disabled—and also sick—deserve a more patient-friendly system of health insurance. Offering them a smorgasbord of private insurance alternatives may appeal to those for whom ''privatization'' is the presumptive answer to all questions of public policy. The political and economic realities, however, are very different.

This type of ''freedom of choice,'' not of doctors but of ''plans,'' would increase the administrative costs and complexity of Medicare while driving most of the old and the sick to distraction. How it would save federal dollars remains a mystery. Moreover, responsible privatization would actually require massive federal regulation of the insurance industry to try to prevent ''cherry picking'' of the better risks and cost shifting between the Medicare and non-Medicare patients by insurers covering both.

The earlier proposal for mandatory HMOs for all generated effective political resistance—and for good reason. Most HMOs have catered to a quite different and much healthier slice of the population. Whether HMOs can serve the elderly and disabled well, and at reduced costs, is unknown.

Reforming Medicare will be neither simple nor painless, and wise solutions are unlikely to emerge from political processes that distort the real issues and the real alternatives. President Clinton should veto virtually any Medicare ''reform'' that emerges from the current, overheated, political context. The president should then remind Sen. Bob Dole and his congressional colleagues of the senator's earlier suggestion for a presidential commission on Medicare that would not report until after the 1996 elections. Handing off to a commission really is the right thing to do now just as it was in achieving sensible tension reforms in the early 1980s.